Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROLF MONTALVO CHEN MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-12-1688-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED, EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's representative, in light of the physical complaints exceeding the extent of compensable injuries and the prior unrelated low back matter, sought and was granted a Designated Doctor exam order from the DWC's local office. The DWC approved the order for the Requestor to perform the exam and issue his report on MMI and IR. The Requestor issued two. One on the instant workers' compensation injury and another combining other and unrelated problems. Whatever the doctor's reasons for this additional undertaking, the charges set by the DWC are known and fixed, subject to modification only upon additional authorized services. The charges submitted exceed the statutory limit and upon the Carrier's review agent's decision to limit those to those allowed by law, the Requestor asked for a reconsideration. This was done and again, based on the Texas Labor Code, the excess charges denied. Requestor appeals. The carrier can see no justification for the above MAR charges demanded by the Requestor."

Response Submitted by: Harris & Harris for Service Lloyds Ins. Co., 5900 Southwest Freeway, Building 2, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 14, 2011	99456-W5-WP	$450.00	$0.00
May 14, 2011	99456-MI	$50.00	$0.00
TOTAL		$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 6, 2011
   - 105 – Additional information needed to review charges
   - 193 – Original payment decision maintained.
   - 151 – Payment adjusted/undocumented services
   - W1 – Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated July 26, 2011
   - 105 – Additional information needed to review charges
   - 193 – Original payment decision maintained.
   - 151 – Payment adjusted/unsupported services
   - W1 – Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated July 26, 2011
   - 18 – Duplicate Claim/Service
   - R1 – Duplicate Billing

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $1,100.00 for CPT code 99456-W5-WP with 4 (four) units in Box 24G of the CMS-1500 for a Division ordered Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division ordered the Designated Doctor to rate the back/coccyx and neck (spine) and the chest (upper extremities). An additional line item was also billed with CPT code 99456-MI representing multiple impairments for $50.00. The respondent re-audited the billing and determined that no additional reimbursement was due when reviewing both codes together.

   28 Texas Administrative Code §134.204(j)(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities including feet).

2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the documentation supports that MMI was assigned and 2 body areas were rated, the spine and the upper extremities. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the MAR per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(a) for the 1st musculoskeletal area using Diagnosis Related Estimates (DRE) method on the compensable

cervical/thoracic/lumbar spine (spinal region) is $300.00 and the 2nd musculoskeletal area on the chest (upper extremities) is $150.00. The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $800.00. Since there are only 3 musculoskeletal areas rather than 4, and only 2 areas were rated, the combined MAR for the MMI and 2 units for the IR areas is $800.00.

3. The respondent has previously reimbursed the requestor the amount of $650.00 for the disputed CPT code 99456-W5-WP. As the 99456-W5-WP has been paid in excess by $150.00, the $50.00 in dispute for CPT code 99456-MI is not recommended for additional reimbursement. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.